Town of Lexington

Office of Community Development
Health Division
1625 Massachusetts Avenue
Lexington, MA 02420
(781)-862-0500 x 84533
Fax (781)-861-2780

Gerard F. Cody, R.E.H.S./R.S.
Health Director x84503

Kathy P. Fox, R.E.H.S. /R.S., C.H.O., CP-FS
Environmental Health Agent x84507

David Neylon, B, S.N., R.N.
Public Health Nurse x84509

Board of Health
Wendy Heiger-Bernays, PhD, Chair
Sharon Mackenzie, R.N., CCM
Burt M. Perlmutter, M.D.
David S. Geller, M.D.
John L. Flynn, J.D.

Recreational Camp Permit

Permit Number: _____ **Current Permit Start Date:** _____

Date: _____ **Fees:** ____ **0-50 campers annually - $200.00**
____ **51-200 campers annually - $300.00**
____ **over 201 campers annually - $400.00**

Please provide the following information:

Name of Camp: _____

Name of Camp Contact Person: _____

Camp Business (Mailing) Address:

_____

_____

Camp Business Phone #: _____ Camp 24 hr Emergency Tel #: _____

Camp Director Name and Age: _____

Camp Director Home Address: _____

Camp Director Home Tel #: _____Camp Director 24 hr Emergency Tel #: _____

Camp Director E-mail Address_____

List the Camp Directors Coursework in Camp Administration and Previous Camp Administration Experience:

_____

_____

Assistant Camp Director Name and Age: _____

Assistant Camp Director Home Address: _____

_____

Assistant Camp Director Home Tel #: _____

Assistant Camp Director 24 hr Emergency Tel #: _____

Assistant Camp Director E-mail Address: _____

List the Assistant Camp Directors Coursework in Camp Administration and Previous Camp Administration Experience:

_____

_____

Site Address of Camp(s): _____

Type of Camp (Check all that apply): Day: _____ Residential: _____Sport: _____

Date(s) Camp Begins: _____

Date(s) Camp Ends:_____

Morning Session Times: _____ Afternoon Session Times: _____

Age Range of Campers: _____ Transportation Used: _____

*Number of Campers_____

*Number of Camp Counselors:_____ *Number of Junior Camp Counselors: _____

*Number of Volunteers: _____

Name of Medical Consultant: _____

Address of Medical Consultant Office:

_____

Medical Consultant Office and 24 hr Emergency Tel #(s):

_____

Type of Medical License (must be a physician, nurse practitioner, or physician assistant with pediatric training):

_____

Health Supervisor Name and Age: _____

Address of Health Supervisor:

_____

Health Supervisor Office and 24 hr Emergency Tel #(s): _____

Type of Medical License, Registration or Training:_____

Signature of Applicant: _____

I understand that by signing this I am attesting to the accuracy of the information provided in this application and I affirm that the camp operation will comply with 105 CMR 430.000 and all other applicable law.

Official Title:_____
Date:_____

* Per Season

For Board of Health Use Only: Date Received: _____ Current Permit Expires: _____